Government of the District of Columbia
Department of Health

District of Columbia
Health and Medical Coalition (HMC)
Healthcare-Associated Infections (HAI) Workgroup

HAI Advisory Committee
899 N. Capitol St. NE, Rm. 582
April 12, 2017 | 10:00am – 12:00pm

Meeting Summary Report

1. Welcome and Introductions

Dr. Iyengar welcomed and thanked everyone for attending the Health and Medical Coalition (HMC) Healthcare-Associated Infections (HAI) Workgroup and Advisory Committee meeting. She then asked everyone in attendance to give their name and affiliation. She reiterated the importance of the committee and stated that the overall goal is to ultimately eliminate healthcare-associated infections.

2. Recap on Mission, Vision and Goals of the Committee

Dr. Iyengar provided a recap on the purpose, mission and vision of the HAI Advisory Committee. The purpose of the HMC-HAI Workgroup and the HAI Advisory Committee is to focus on HAI prevention and to give voice to a wide range of healthcare stakeholders both within and between various healthcare settings and among healthcare professionals. The Committee is also charged with making high-level recommendations to DC Government. The mission of the Committee is to identify HAI prevention activities, recommend evidence-based practices and sustainable interventions, establish targets, and monitor and communicate progress to stakeholders and the public. The vision is to help healthcare facilities to provide the best possible quality of care in the District by ultimately eliminating HAIs. Goals of this meeting include continuing the conversation about potential committee priorities, creating a plan of action for moving forward with identified priorities, and developing a big-picture timeline with tangible outcomes.

3. Recap on Committee Roles and Responsibilities

Emily provided the Committee with an overview on the expectations surrounding serving as a member. One of the main reminders was that the Committee was formed to have representation from diverse stakeholder group as opposed to having representation from individual healthcare facilities. The purpose of this was to make the Committee more inclusive while remaining small enough to facilitate substantive discussion. Therefore, professional associations, which are made up of various healthcare facility representatives, were invited to join the Committee by nominating 1-3 representatives.

In order for the Committee to serve its dual purpose of facilitating productive conversation while remaining inclusive to larger groups through various means of transparency, DOH is expecting Committee members to serve as liaisons between the Committee and their larger stakeholder groups. This means bringing information to the committee from their respective colleagues in their fields/associations as well as disseminating information from the Committee back to their colleagues in their respective fields/associations. In addition, regular Committee member attendance is tantamount to the success of the Committee's mission and vision.

Overall the DC HAI Advisory Committee is charged with making recommendations to DC DOH when it comes to planning, implementing and evaluating HAI prevention activities within the District. The HAI Program is acutely aware of the need for diverse expertise and diverse sector consensus when it comes to addressing the issues related of HAIs.

4. Research Findings from the HMC HAI Workshop

The HAI Program provided an overview of the HAI Spring Workshop, which was hosted by the Health and Medical Coalition HAI Workgroup, with the assistance of the Delmarva Foundation, the DOH Health Regulatory and Licensing Administration and the DOH HAI Program. This half-day workshop was comprised of didactic lectures and two interactive structured brainstorming sessions.

<u>Workshop Overview</u>

Speakers included the HAI Program and HMC supervisors, Dr. Preetha Iyengar and Aisha Williams, respectively, as well as the Department of Health's Chief of Staff, Dr. Jacqueline Watson; all of whom provided overviews about their individual programs. Local antimicrobial stewardship (AS) expert, Dr. Mia Barnes talked about the importance of antimicrobial resistance (AR) and the various initiatives that George Washington University is currently spearheading. The keynote speaker was Dr. Denise Cardo, who

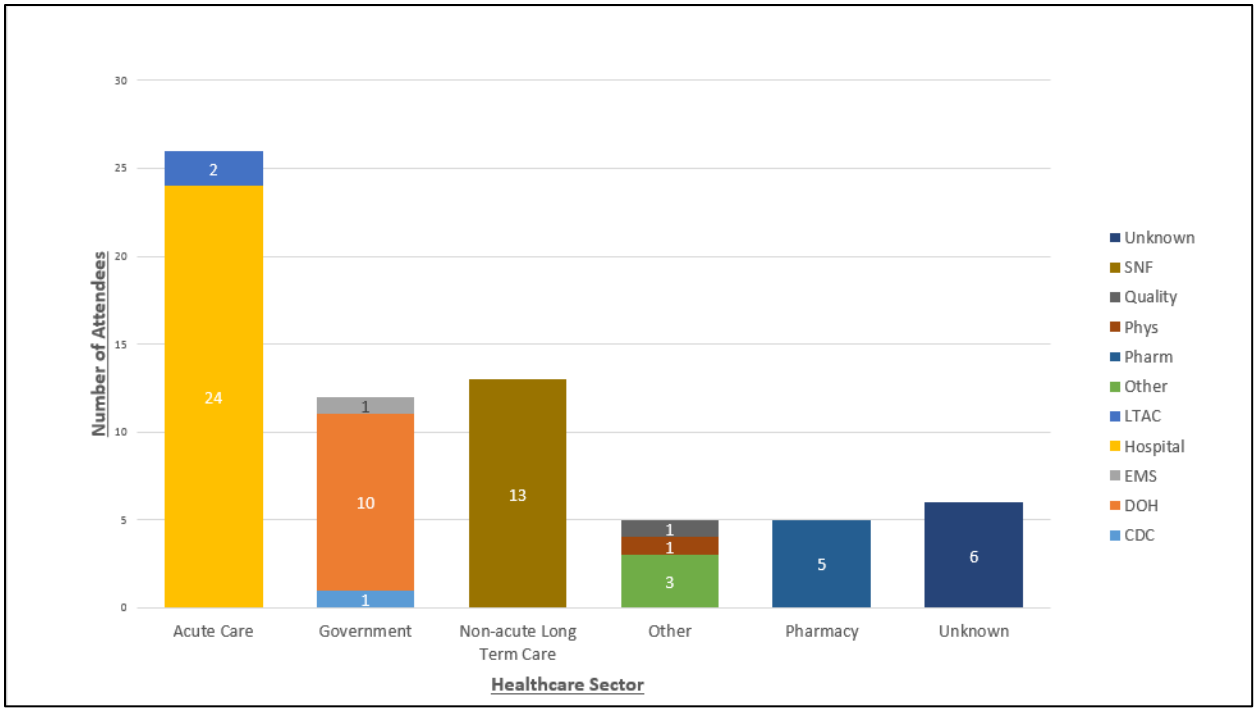

Figure 1: Healthcare sector roles in attendance at the 2017 HAI Spring Workshop

serves as the Director for the CDC Division of Healthcare Quality and Promotion. Dr. Cardo provided an overview on the national importance of addressing the issue of HAIs (including AR and AS) and how the District of Columbia plays an important role in fighting this winnable battle.

In total there were around 70 attendees from five different healthcare-related sectors (acute care, government, non-acute long-term care, etc.) (*Figure 1*) who served in a wide range of healthcare-related positions (physician, pharmacist, infection preventions, corporate staff, etc.) (*Figure 2*).

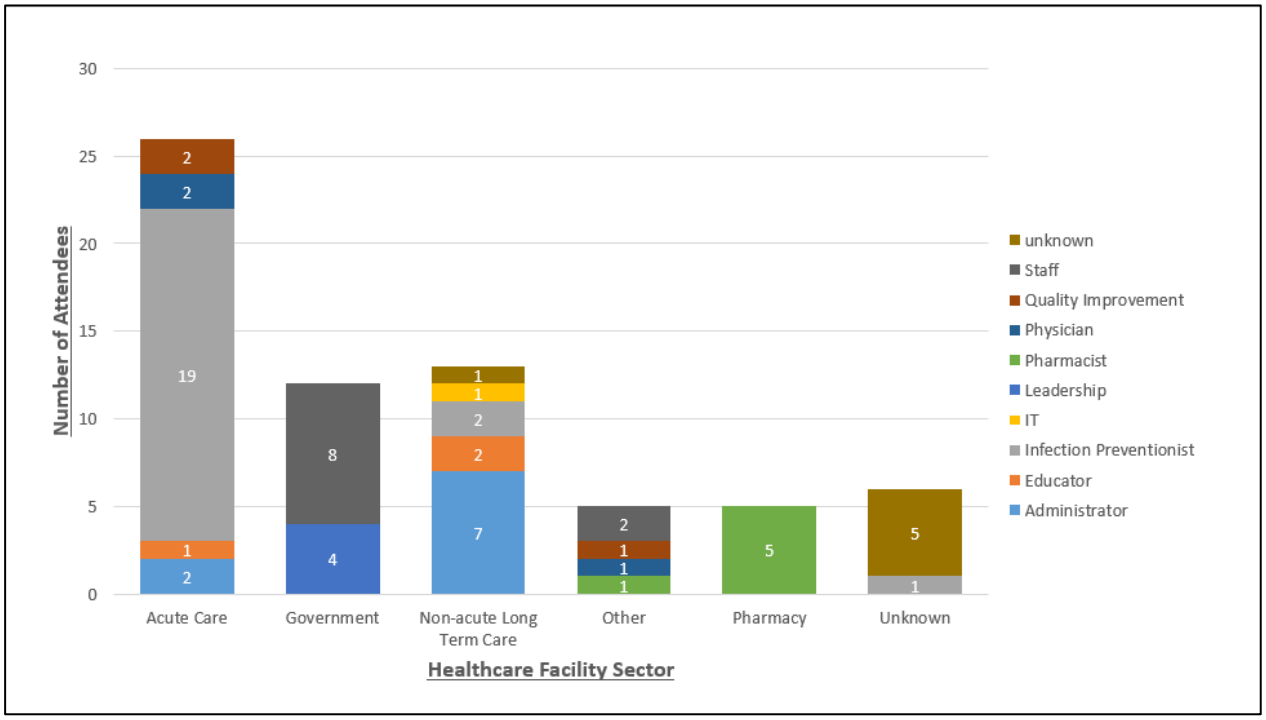

Figure 2: Healthcare facility positions in attendance at the 2017 HAI Spring Workshop

The latter half of the workshop included an active brainstorming session where attendees were broken out into 10 separate groups of roughly 5-10, with mixing as much as possible of individuals with those from a different healthcare sector or a difference healthcare role. All the groups worked through two questions, each of which was led by a different facilitator.

Structured Brainstorming Session

One question asked "What HAI and MDRO is of the greatest concern to the District as a whole?" and had accompanying sticky notes with various HAIs and MDROs (etc. CLABSI, CDI, MRSA, etc.). The groups were asked to discuss among themselves how to prioritize these HAIs and MDROs and ultimately place them on a 2x2 grid comparing urgency and concern (*Figure 3*).

The other question asked "How can collaboration across the healthcare sector be improved to enhance HAI and MDRO prevention and reduction?" and was accompanied by a 4x4 grid that compared the acute, SNF, outpatient, and government sectors. The groups were asked to discuss amongst themselves how to answer this question (e.g. how can acute care work better with SNFs, how can government work better

with acute care, etc.) and then write their responses within one of the boxes on the 4x4 grid. Participants were also encouraged to consider how inter-sector collaboration could be improved within their own healthcare facilities (e.g. how can pharmacy work better with quality improvement, etc.) (*Figure 4*).

All 10 groups identified CDI as the most urgent HAI and of the greatest concern for the District, and 7/10 groups identified CRE as the second most urgent HAI and of greatest concern to the District. MRSA and SSIs were identified as a greater concern but less urgent by 6/10 and 5/10 groups, respectively (*Figure 5*).

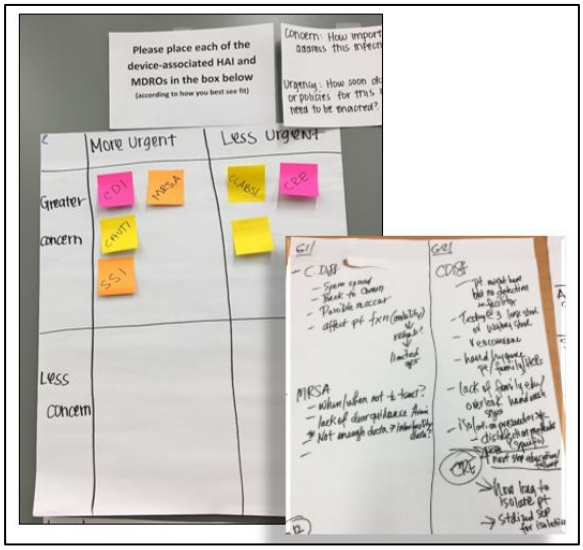

Figure 3: Structure brainstorming session question "What HAI and MDRO is of the greatest concern to the District as a whole?"

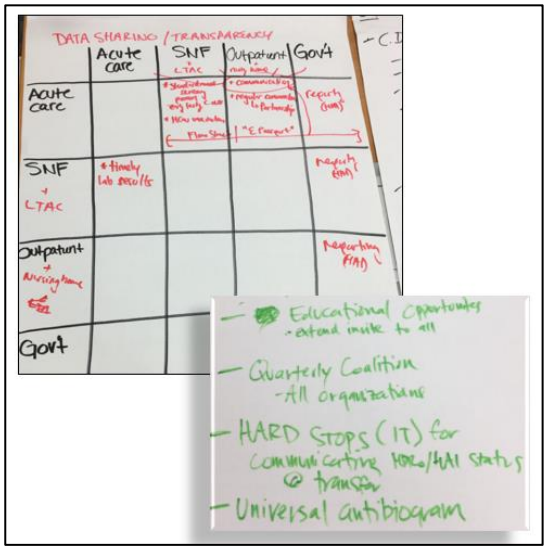

Figure 4: Structure brainstorming session question "How can collaboration across the healthcare sector be improved to enhance HAI and MDRO prevention and reduction?"

	More Urgent	Less Urgent
Greater Concern	CDIFF - 100% (10/10) CRE - 70% (7/10) CLABSI - 50% (5/10) CAUTI - 40%(4/10) SSI - 30%(3/10) HAP/VAP - 10% (1/10)	MRSA - 60% (6/10) SSI - 50% (5/10) CAUTI - 40% (4/10) CLABSI - 20% (2/10) CRE - 20% (2/10) VRE - 20% (2/10) VRSA/VISA - 10% (1/10)
Less Concern	CLABSI - 20% (2/10) CRE - 10% (1/10) VRE - 10% (1/10) SSI - 10%(1/10)	MRSA - 30% (3/10) CAUTI - 20% (2/10)

Figure 5: Responses to the structure brainstorming session question "What HAI and MDRO is of the greatest concern to the District as a whole?"

Specific CDI concerns noted by the groups included undiagnosed infections in facility, testing recommendations, possible re-occurrence, spore spread (disinfection methods), community

transmission, and antibiotic use. A specific CRE concern noted was about standardized guidelines surrounding the recommended length of isolation. Specific concerns noted about MRSA included how and when to conduct surveillance, a lack of guidance and training, and not enough interfacility data.

There was a group consensus that communication across the board needed to be improved. Many groups discussed the need for routine, standard, and meaningful communication. Poor communication was especially a problem during the patient discharge/transfer process, where some participants reported having to "hunt down" or go on a "wild-goose chase" to obtain the appropriate information for a successful transfer/discharge; delayed receipt of laboratory results was also major component. Aside from the patient transfer issue, groups suggested that more regular communication and partnership between facilities was needed in general. Another idea that was brought up was some sort of platform that served as a "one-stop-shop" for accurate and timely points of contacts for all health care facilities involved with patient care.

With regards to improving the role of government, participants suggested better communication of new or revised reporting regulations because the associated guidance would assist in the implementation of facility level policies and protocols. Another opportunity for improvement that was mentioned is the need for standardization of definitions, policies and practices related to infection prevention and control. It would be useful to have a clear understanding of how terms are used in different healthcare settings as well as how screening and isolation policies differ by facility and setting.

Another common theme was the need for improved data sharing, especially via electronic systems, and increased transparency. HCPs and other ancillary providers encounter individuals with HAIs and MDROs in a variety of healthcare settings (hospitals, home health, dialysis centers, etc.) and providers need to have access to the patient's condition/medical history in order to properly treat and minimize spread of MDROs. Groups also highlighted the importance of collaborative meetings and workshops (similar to the 2017 Spring HAI Workshop) in order to increase the communication across sectors, increase general networking opportunities, and promote the sharing of best practices.

5. Discussion about Short and Long Term Committee Priorities

Emily provided the Committee with a recap of the potential priorities mentioned during the September 2016 and November 2016 meetings. These included (in no particular order of importance) 1) communication about patient transfer, 2) training and education about appropriate antimicrobial use, 3) health Information Exchange (HIE)/Inter-facility Information Sharing (IIS), 4) District/regional/facility level antibiograms, 5) the need for a short-term solution to address MDRO/HAIs during patient transfer process (i.e. interfacility transport, movement and previous exposures), 6) the need for a long-term solution to address communication around interfacility discharge and transfer processes, and 6) the need to frame and refine Advisory Committee goals with regards to specific HAIs of focus.

Committee members were asked to take into account the workshop findings and, in conjunction with their own experience and expertise, discuss what they thought should be short and long-term priorities of focus for the Committee (i.e. outcomes-based priorities that could be accomplished during the next 6-12 months and 3-5 years).

Discussion surrounding the "Chesapeake Regional Information System for our Patients" (CRISP) ensued as an initial item. A representative from Delmarva Foundation (DF) mentioned that figuring out who is

contributing to and excluded from CRISP is important information to have with regards to moving forward with this system. Pharmacists are currently not included in this system. Dr. Iyengar asked the Committee members how CRISP is utilized by doctors and an acute care representative mentioned that it is used frequently at their facility. A DCHA representative said they are working with their members to better understand how and when it's utilized and its overall perceived usefulness. This same DCHA representative said a Health Information Exchange (HIE) subcommittee within the District is getting a resurgence and that this can be further discussed there. A DCPCA representative said that DCPCA is supporting CRISP through various funding channels and is looking into how outpatient HIEs can connect with pharmacy data. DCPCA purchased a platform that the Medicaid office is also using, which CRISP feeds into. Right now DCPCA only gets data from Medicaid claims and not from any of the corporate pharmacies, such as CVS. A DF representative mentioned that CRISP is working with Surescripts to coordinate their two systems and an acute care representative said they had never used CRISP to lookup prescribing data and are therefore unsure of its utility within that capacity.

A ROAR representative said it's important to also understand the degree to which CRISP consistently has data of interest. This might be an opportunity for the Committee to recommend a pilot study that includes a few different health care facilities (HCFs), which could potentially be funded through a grant. One other thing to keep in mind, however, is that when taking on IT projects that include protected health information, things can become overly complex very quickly due to architecture and privacy issues. Another thing to consider is that there's a lot of research going on about hospital readmission and this may be a way to find out about the ecology of this processes such as whether or not patients are readmitted due to patients being discharged with inaccurate lists of medications.

A DCHA representative pointed out the importance of keeping the Committee priorities measureable and outcome-based and that metrics should be part of the conversation. Another short-term priority for consideration would be identifying or creating checklists that assist different types of HCFs with MDRO risk stratification. Dr. Iyengar mentioned that when developing any type of guidance or protocol, it would be best to focus on one organism at a time, such as CDI, while making the overall project as generalizable as possible. The discussion shifted towards balancing the need for resources when implementing any AS initiatives, especially within the SNF sector. The SNFs don't yet have clear guidance on risk stratification for MDROs, which adds an extra layer of difficulty with trying to add AS activities within these facilities. A SNF representative said that any AS initiatives would have to be well thought out beforehand in order to maximize the low amount of available resources.

A Pharmacy representative brought up the importance of using data to inform AS activities within the SNFs and other healthcare facilities. Low hanging fruit might be using the data to assess current prescribing practices and use that information to incentivize a more active role of SNF pharmacists in AS activities. A SNF representative mentioned that prescribing physicians often seem more receptive to AU feedback when it comes from a pharmacist as opposed to from a nurse. Overall the Committee seemed to be in agreement that getting pharmacy to more actively play a role in AS activities at the SNFs, as well as incorporating other educational, networking, and mentoring activities, is critical to strengthening overall AS initiatives. Dr. Iyengar also mentioned that having Pharmacists play a more active role in interacting with prescribers would be a much better approach than trying to standardize or protocolize prescribing practices, which is unfeasible from a physician standpoint.

A Pharmacy representative mentioned that an AS Toolkit is available from the American Society of Consultant Pharmacists; however, a few SNF representatives said that additional guidance is often needed

when implementing toolkits at the facility level. Toolkits are often too broad or non-specific to be implemented by staff or facilities who are unfamiliar with infection control or AS practices. Dr. Iyengar and an acute care representative said that emergency departments are another sector greatly in need of AS intervention, especially since this serves as a conduit between SNFs and hospitals.

Short-term potential priorities

- Checklists/detailed guidance documents for infection control staff
- CRISP utilization by both acute and non-acute care facilities
- Assessing AU and CDI with Medicaid data or other data sources

Long-term potential priorities

- Improve condition specific diagnoses
- Figure out how to engage SNF prescribers in AS activities
- Create partnerships to capitalize on expertise

Overarching priorities

- Address CDI in the District
- Implement strong antibiotic stewardship programs in the District

6. Next Steps

- Formalize a big picture timeline for the Committee
- Document consensus about priorities
- Identify priority co-leads

7. Adjournment: Next Meeting Date – June 14, 2017 (in-person)